Request for Proposals
by
The Appalachian Regional Commission
for

An Analysis of Disparities in Mental Health Status and Substance Abuse Prevalence in the Appalachian Region and Access to Mental Health and Substance Abuse Treatment Services

July28, 2006

Proposals due on or before August 28th, 2006

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An Analysis of Disparities in Mental Health Status
and Substance Abuse Prevalence, and
Access to Treatment Services in the Appalachian Region

I. Introduction. The Appalachian Regional Commission (ARC) invites proposals from qualified researchers and consultants to analyze disparities in the mental health status and substance abuse prevalence in the 410 county Appalachian Region, as well as the access to treatment services based on readily available county-level health data. The first task is to develop a consistent database of available national, state, sub-state, and county-level information on diagnoses and treatment of mental health conditions and substance abuse, including inpatient and outpatient services, emergency intake and diagnoses, rehabilitation services, clinics, licensed practitioners and other providers (for a listing of the 410 Appalachian counties by state, and a map of the Region please see http://www.arc.gov/index.do?nodeId=2947). Where feasible the data should include age, sex and race and relevant socioeconomic information, as well as the metro/non-metro designation of the county, in order to provide a comparative framework for analysis of mental health status and disparities and substance abuse and treatment in the Appalachian Region and the rest of the nation. A second task is to identify whether there are specific disparities in mental health diagnoses and prevalence substance abuse in the region as compared with the rest of the nation. A third task is to identify and analyze available data to measure the accessibility to mental health care and substance abuse treatment within the region, including the location of mental health providers, a lack of insurance coverage, state limitations on Medicaid health services covered, and problems of transportation accessibility. A final task is to develop a set of criteria and protocols for identifying relevant case study communities within the ARC Region that illustrate local responses to problems and solutions and which document in richer detail the situation confronting Appalachian communities, particularly distressed counties. In particular, ARC wants to identify innovative or promising state or regional programs that are addressing these needs in the Region. Furthermore the case studies should help ground the results of this regional analysis, as well as identifying important gaps and problems in secondary data.

The Commission's purpose in conducting this research is to provide baseline data and analyses of disparities in mental health status and substance abuse prevalence so that policy makers can better understand the dimensions of the perceived regional problems. In addition, this research aims to assist regional public health practitioner's surveillance and research, health education, and investments to improve the delivery of mental health care, and treatment outcomes.

II. Scope of Work

This research project will analyze and report in a written narrative the findings on disparities in mental health status and substance abuse, and access to treatment in the 13-state Appalachian Region. Proposals should develop an outline for the research, a detailed methodology, and a general plan for a report. The report will need to summarize the findings in narrative form and fully relate the narrative to any descriptive statistics, graphs and tables.

The specific topics that should be included in the proposal are:

- A framework for developing analyses of disparities in the diagnoses and treatment of mental health and substance abuse prevalence, and access to treatment services comparing Appalachian and non-Appalachian counties;
- A framework for analyzing the relationship between relevant demographic and socioeconomic variables and mental health status and substance abuse prevalence;
- An analysis of the sources and costs of data needed to carry out the analyses;
- A framework for policy analysis of the findings for further surveillance, the role of mental health care financing, research planning, community-based research and, translation of findings for outreach and education;
- A protocol for identifying relevant case study communities and a conceptual outline for conducting the case studies.
- A clearly articulated plan for conducting the research work, and developing the written report and final data base and graphic products.

Preliminary research by ARC staff has determined that state and sub-state data are available on treatment services, particularly through the *Center for Mental Health Services Uniform Reporting System* (see the SAMHSA web link for CMHS at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp) and through the state mental health agencies. Data on the geographic distribution of diagnoses of mental health conditions may be much more difficult to procure due to confidentiality reasons, particularly with detailed data on diagnoses such as identified in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DMS IV)*. Data on the location of mental health services are readily available through the *Mental Health Services Locator* (see the SAMHSA web link for the MHSL by state and county http://www.mentalhealth.samhsa.gov/databases/kdata.aspx?state=WV).

Deliverables

The contract will require a draft and final report with an executive summary, although the contractor may want to consider breaking the report into two volumes: the findings from the regional data analysis; and the case study findings (with different due dates for each volume). The final report(s) suitable for photocopying, an electronic copy of the final report(s), and an electronic data base (in an agreed upon software formats) with a complete data dictionary (subject to confidentiality restrictions from data providers) must be submitted upon completion of the project.

III. Methodology

The successful applicant will develop a complete methodology to analyze the topics specified in the scope of work.

The methodology should include:

- A review of relevant literature on incidence and explanations for mental health disparities and substance abuse prevalence and disparities in access to treatment in rural areas.
- Specification of the secondary data sets for an analysis of disparities in mental health status and substance abuse, and access to treatment in the 410 county region, with public or proprietary data sources identified;
- Methods for the compilation of data, and application of statistical techniques for analysis of disparities, and techniques for testing for geographic disparities;
- Discussion of limitations on geographic coverage by specific data sets and methods to address these issues, including pooling time series, and/or aggregating geographical sub-regions to provide adequate coverage;
- Discussion of potential data acquisition problems which may pose risks for the project timeline given the current state of the data and the confidentiality restrictions on geographically detailed data by type of diagnoses.
- Discussion of the protocols for selecting potential case study sites and the conceptual design for conducting the case study research.
- Discussion of a geographical framework and data base to summarize and present the findings and results for the Appalachian portions of the 13-state Region.

Proposals can offer other methodological procedures as needed.

IV. Cost and Timing

The Commission rates this research project as a Large-scale Research project according to ARC's rating of the level of effort for conducting research: Major research projects $250k-$300k+; Large–scale $150 to $249k; Medium–scale $75k to $149K; Small–scale $25k to $74k; Research Brief less than $25k.

The contract will be a FIRM FIXED-PRICE CONTRACT. The Commission anticipates that the research will take 18 months to complete.

Overhead Policy

The Appalachian Regional Commission's policy on allowable indirect overhead costs for university-based research has been to permit universities to charge the same rates charged to their own state agencies. For the purposes of the project under current discussion, an indirect overhead of 15 percent would be in keeping with research contracts of this size.

V. Evaluation of Proposals

All proposals will be evaluated based on the following criteria:

- Clear and complete understanding of the study objectives and tasks;
- Command of existing analyses and public policy on mental health disparities and substance abuse issues;
- Complete, clearly articulated, logical study design and technically competent methodology;
- Demonstrated ability to synthesize and interpret research findings in a credible and useful manner;
- Qualifications, relevant prior experience, and capability to carry out and support the project in a timely fashion;
- A credible management proposal;
- The cost-effectiveness of the proposed project design.

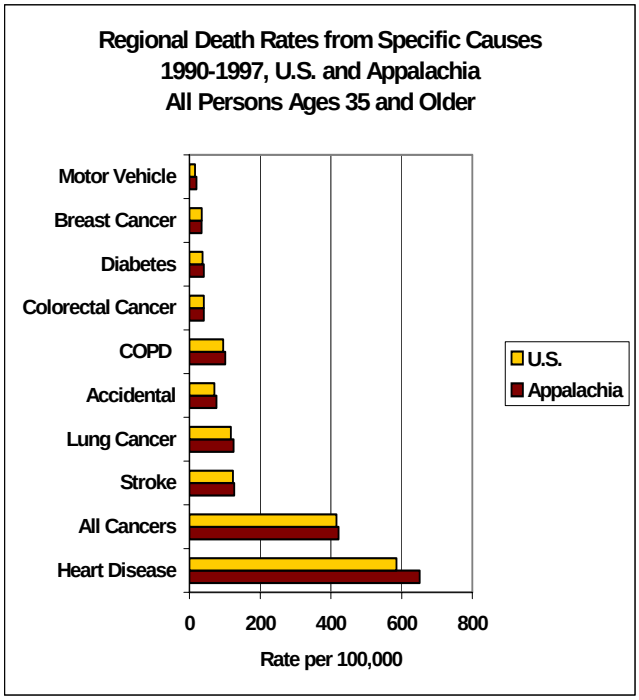
VI. Proposal Submission

An original and three copies of the proposal must be submitted to the Regional Planning and Research Division, Appalachian Regional Commission, 1666 Connecticut Avenue, NW, Suite 700, Washington, D.C., 20009-1068, on or before **August 28, 2006**. For information contact Greg Bischak, Senior Economist, by phone at (202) 884-7790 or by e-mail at gbischak@arc.gov or contact Dr. Henry King, Director of Program Operations, by phone at (202) 884-7779 or via email at hking@arc.gov.

VII. Background on Health Status in Appalachia

An Analysis of Disparities in Health Status and Access to Medical Care in the Appalachian Region, conducted by Joel Halverson and other researchers at West Virginia University in 2004, shows that significant health disparities persist in the Appalachian region. The region as a whole suffers considerable excess in mortality from leading causes of death when compared to the non-Appalachian U.S. Furthermore, there is a high degree of within-region variability in both the rates of mortality and hospitalization. Many Appalachian counties with the most adverse health outcomes correlate geographically with socioeconomic characteristics, behavioral risk profiles, and available medical care resources. However, there does not appear to be a consistent relationship between all factors combined for individual counties. It appears that reasons for disparities in health outcomes are highly variable and localized. Identifying the causes of inconsistencies may help in developing effective interventions and policy at the local level.

- Overall, the Appalachian region experiences excesses in mortality from many of the major causes of death and illness relative to the non-Appalachian U.S.



Source: Joel Halverson, et.al., WVU, 2004

- To clarify the extent and nature of regional excesses, analyses have been conducted for eight demographic subgroups for leading causes of death and illness; white and black men and women ages 35 to 64 and 65 and older.

- County-level analyses also have been conducted in order to identify disparities within the Appalachian region and highlight clusters of counties that exhibit both favorable and adverse health outcomes in the region.

- Additional data are examined which may help to explain observed disparities including, socioeconomic conditions, behavioral risks, and available medical care resources.

- Together, these data provide a detailed account of health status in the Appalachian region and provide evidence for targeted interventions as well as avenues for further research.

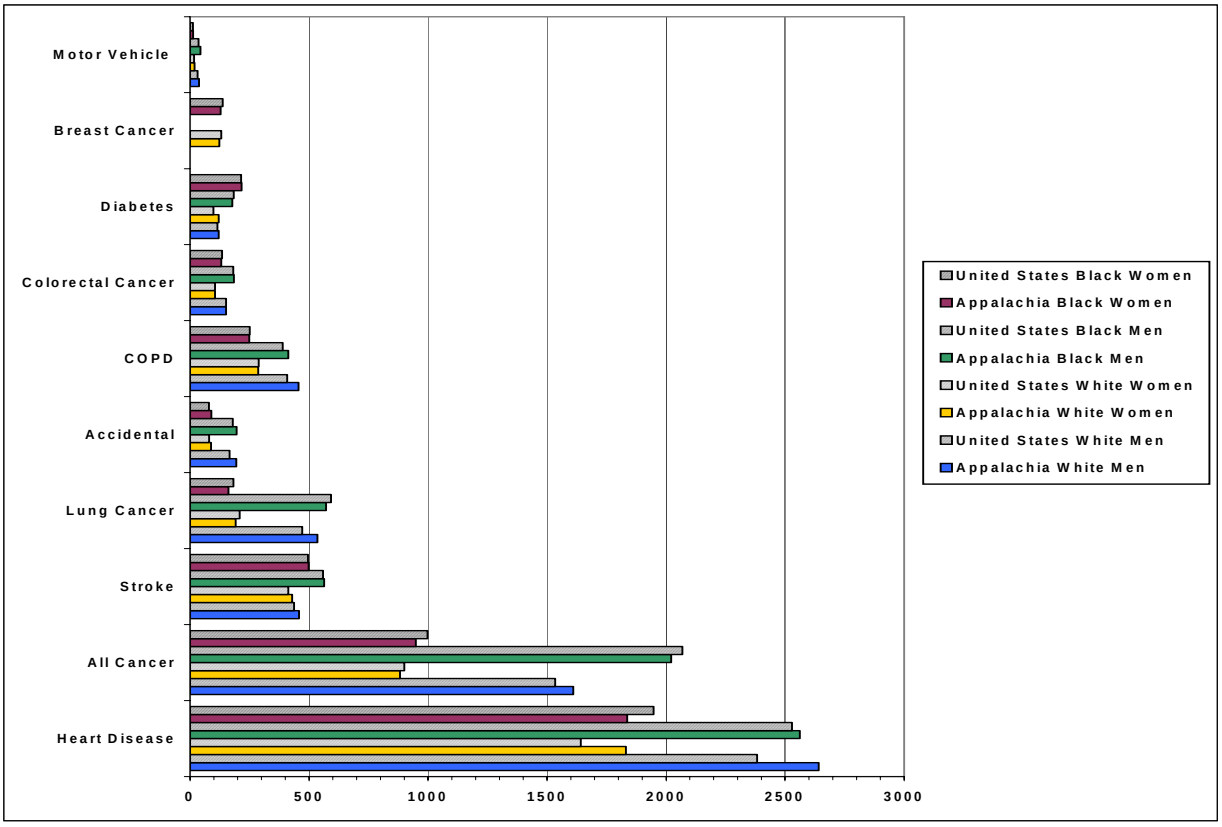
- These data suggest that variations in health status within Appalachian are, to a large extent, highly localized and therefore, achieving Healthy People 2010 objectives will require intervention at the local level.

Mortality Analysis

Mortality statistics provide the most comprehensive source of information available for examining public health outcomes among population subgroups and/or geographic areas. The analyses conducted in this study help to situate the mortality experience of the

Appalachian region with the rest of the United States. The specific causes of death that were analyzed are heart disease, cancer(s), cerebrovascular disease (stroke), chronic obstructive pulmonary disease and allied conditions, diabetes, accidental deaths, deaths from motor vehicle accidents, and suicide. The study population consisted of black and white men and women who resided in the United States during the period 1990-1997. Each of these sub-groups was divided into two age categories: 35 to 64 and 65 and older. Deaths which occur in the 35 to 64 age-groups are considered premature and preventable.

Regional Death Rates from Specific Causes, U.S. and Appalachia, 1990-1997 – Persons Ages 65 and Older



Source: Joel Halverson, et.al., WVU, 2004

The Appalachian region as a whole experiences excess mortality compared to the non-Appalachian U.S. Among the causes of death examined in this study, Appalachian populations suffer the most significant excesses in heart disease mortality, the leading cause of death in the U.S. There are, however, considerable differences in the burden of mortality among age/gender/ethnic groups. In addition, the Appalachian region suffers an excess in premature deaths (among persons ages 35 to 64) from heart disease, all cancers combined, lung cancer, colorectal cancer, chronic obstructive pulmonary disease, diabetes, and motor vehicle accidents, relative to comparable non-Appalachian U.S. population. All Cause death rates are consistently higher among Appalachian population subgroups compared with U.S rates, with the exception of black men ages 35 to 64 and black women ages 65 and older.

Suicide Mortality in Appalachia. The relatively small numbers of suicides at the county-level is evident in both the small value of the suicide rates as well the narrow range of the values in each distribution. Several high rate counties are coincident for ages 35 to 64 and 65 and older. These counties generally appear in Eastern Virginia and along the West Virginia border. Two high-outlier (unusually high value) counties are apparent among persons ages 65 and older. These counties occur in Eastern Virginia and Northeastern Alabama and generally seem to mark the ends of a swath of high rate counties that occur in the central to southern portions of the region.

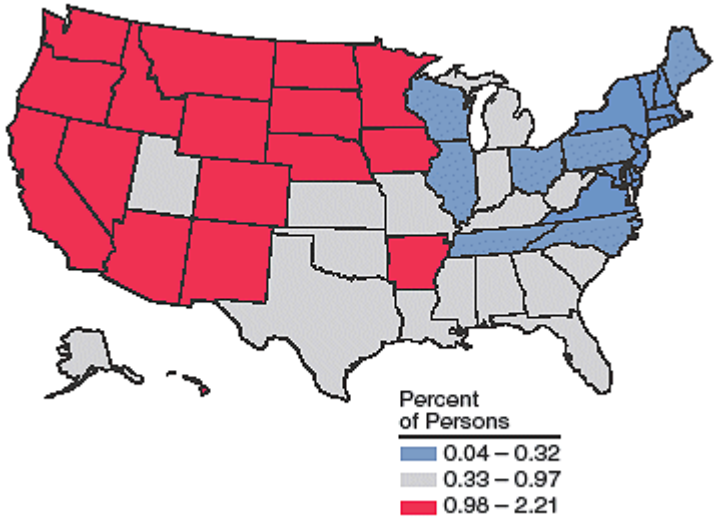
VIII. Background on Substance Abuse in Appalachia

Preliminary analysis by ARC staff of Department of Justice, Department of Health and Human Services and the Drug Enforcement Administration data reveals the following apparent patterns and trends in the nation and the Appalachian Region:

- In 2004, 19.1 million Americans or 7.9 percent of the population aged 12 or older, were current illegal drug users, of which 583,000 people were reported as methamphetamine users (or two-tenths of one percent of the population aged 12 or older). While the survey is based on self-reported data, it provides the best trend data on use. Source: the Substance Abuse and Mental Health Services Administration (SAMHSA) *2004 National Survey on Drug Use and Health*, pp. 3 and 10. (http://www.oas.samhsa.gov/nhsda.htm)
- Sub-state data derived from the SAMHSA household survey, while undoubtedly exhibiting a down bias due the self-reporting by respondents, (http://oas.samhsa.gov/subStateTABS/toc.htm) indicates several areas reporting slightly higher levels of any illicit drug use in the Appalachian portions of the 13-state region, although **none** report very high levels of use compared to the non-Appalachian portion of the states:
    - Pennsylvanian counties of Allegheny, Washington and Greene report the highest levels of use for marijuana, cocaine and other illicit drugs.
    - North Georgia and part of eastern Tennessee indicate elevated illicit drug use, particularly of cocaine;
    - Eastern Kentucky data indicates higher marijuana use;
    - Northern and northwestern parts of West Virginia indicate high use of marijuana and other illicit drug use;
    - Southwest Virginia data indicate slightly elevated illicit drug use;
    - Southeastern Ohio slightly elevated marijuana use and other illicit drugs;
    - Western Maryland indicates slightly higher marijuana and cocaine use;
    - Northern Alabama indicates slightly higher marijuana use;
    - Western North Carolina indicates relatively high marijuana use;
    - Northeast Mississippi data indicates relatively higher marijuana use.

- SAMHSA data on methamphetamine use indicate a clearly higher use rate in the western U.S. as compared to the rest of the nation, and show lower rates in KY, TN and VA than elsewhere in the east.

Methamphetamine Use in Past Year among Persons Aged 12 or Older, by State: 2002, 2003, and 2004



Source: (http://oas.samhsa.gov/2k5/meth/meth.htm).

- Drug Enforcement Administration data on seizures of clandestine methamphetamine labs indicate that 18 percent of national seizures (1,846 of 10,229 labs nationally) occurred in the Appalachian Region, with 45 percent of Appalachian labs (823) occurring in Appalachian Tennessee. (Source: National Clandestine Laboratory Seizure System, EPIC, 2005).
    - DEA data indicate however that practically all of these labs are very small-scale operations producing less than 2 ounces of methamphetamine.
    - DEA reports also indicate that 80 percent of all methamphetamine comes from super-labs in other countries, particularly Mexico, and that most domestic production comes from super-labs in the western U.S., especially California.
- Department of Justice statistics on Drug-related violent crimes nationally indicate a sharp reduction since 1989, particularly drug-related homicides which have fallen by half since 1989 from 7.9 percent of all homicides to 3.9 percent in 2004. (http://www.ojp.usdoj.gov/bjs/dcf/duc.htm)
    - Region-wide data on drug-related violent crimes and homicides are not readily available, although 2000 data from the Bureau of Justice

Statistics indicates that methamphetamine-related crimes are much higher in the western U.S.

- Also see: http://oas.samhsa.gov/2k5/arrests/arrests.cfm

- The Drug Abuse Warning Network (DAWN) of SAMHSA reports on a sample of emergency department medical records and death investigation cases to determine which cases are related to substance abuse and how many deaths are drug-related. While DAWN does not provide a national estimate of drug-related deaths, it does provide some state and sub-state data for parts of the Appalachian Region:
  - Maryland county-level data, including Allegany County, stands out as a non-metro county with a relatively high rate of drug-related deaths in 2003.
  - Birmingham-Hoover Alabama also participates in the system and reported 135 deaths per million in 2003 due to drug-related causes.

IX. Background on the Financial Conditions of Health Care Institutions and Access to Care in the Appalachian Region and their Economic Impacts

This report written by Jeffrey Stensland, Curt Mueller, and Janet Sutton, of Project HOPE**,** Center for Health Affairs for ARC and published in 2003 describes the availability of health care services in Appalachia, the financial stability of Appalachian health care institutions, and the effect of hospital closures on Appalachian counties.

An important overall finding of the report is that the core of the Appalachian health care infrastructure has been getting stronger. There has been an expansion in the number of primary care physicians per capita in Appalachia. Even distressed counties are attracting more primary care physicians.

- Physician supply increased from 1990-1999.
- Distressed counties attracted increasing numbers of primary care physicians.
- The number of skilled nursing facilities increased through 1999.
- Profits at Appalachian skilled nursing facilities were above national averages.
- Most county economies were resilient to the closure of hospitals.
  - In counties that lost a hospital, income per capita grew at rates similar to the average for Appalachia.
  - Counties that lost their only hospital experienced a rate of population growth that was similar to the average for rural Appalachia.
  - Counties that lost their only hospital usually experienced employment growth, though the long-term rate of job growth tended to be slightly lower than Appalachian averages.

The analysis of Appalachian hospitals based on American Hospital Association (AHA) data revealed shortcomings in access to certain services that fall outside the core functions of primary-care physicians, rural hospitals, and skilled nursing care facilities. Most Appalachian counties have not been successful at improving access to dentistry,

outpatient alcohol treatment, outpatient drug treatment, and outpatient mental health services.

- Low levels of dentists per capita, particularly in distressed counties. The supply did not improve from 1987 through 1998.
- **A lack of hospital-affiliated substance abuse treatment services, particularly in distressed counties.**
- **A lack of hospital-affiliated psychiatric services, particularly in distressed counties.**
- Lack of obstetric care in economically distressed counties.

X. Background on the ARC's Health Programs

For more than 40 years, ARC has been an advocate for and partner with the people of Appalachia to create opportunities for self-sustaining economic development and improved quality of life. In developing long-term solutions to Appalachia's economic and social isolation, several key goals have been targeted, including improved health care. ARC works with many partners including the Region's communities, local institutions, non-profit organizations, state governments and other federal agencies to effectively leverage its resources to provide access to health care and comprehensive services for all Appalachians.

In 1964, when the President's Appalachian Regional Commission released its report on Appalachia's socioeconomic conditions, the Region's health status was grim: death from infectious diseases was 33 percent higher in Appalachia than the rest of the nation; there were 30 percent fewer doctors per 100,000 people than the national rate; infant mortality rates in many of the Region's counties were twice the national rate; access to the nearest clinic or hospital was limited; and numerous public health problems plagued many of the Region's counties, such as poor-quality drinking water, and a lack of public sewerage treatment systems.

In 1965 the *Appalachian Regional Development Act* established the Commission as a federal-state partnership with the 13 Appalachian states, and created a Health Advisory Committee to advise the Commission on health priorities and provide guidelines for investments. The Health Advisory Committee recommended three priorities: develop demonstration health areas where health facilities would be built and modernized; attract substantial numbers of health providers to the Region; and use demonstration areas to develop the full range of health services, including health education, and preventive, diagnostic, therapeutic, rehabilitative, and environmental health services.

At first, in 1967-68, eight demonstration health areas were established, but by 1970 the number had grown to 12 demonstration areas in 12 states. These efforts paid off as several of the demonstration areas developed model comprehensive health care services including coordinated systems of home and community health services which helped put basic health-care services within a 30-minute drive of many previously underserved people. In addition, these demonstration areas expanded health care training opportunities

in health occupations, and pioneered such concepts as the use of physician assistants and area-wide health planning.

Health investments peaked as a share of the ARC's total non-highway spending in 1970 at 46 percent ($47 million), fell and then rose to 42 percent ($57 million) in 1976, and then began a steady decline, falling to about $26 million or a 24 percent share of total spending in 1979. A major focus of the Commission's work in the 1970s was the construction and modernization of a network of 400 primary care clinics, with 250 receiving direct funding from the Commission. From 1966 to 1980, the Commission invested nearly $115 million in primary care improvements. Hospital services likewise became an area of concern with investment amounting to $116 million during the 1966-1980 period. In addition, through the 1970s, ARC made investments of $49 million in mental health services, $22 million in emergency medical services, $26 million in health professionals training and recruitment, and nearly $15 million in maternal and child care.

In 1982, with the expectation that ARC's funding would be substantially reduced, the Commission proposed to Congress a three-year "finish-up" program, including a major health objective. The health finish-up program addressed the areas of highest need: an increase in the availability of primary care in 66 high-need counties; a reduction in high infant mortality in 33 counties that had infant death rates 1.5 times or higher than the national average; and the recruitment of additional physicians and health care professional to the region.

By 1985, the health finish-up program had come to a close with $15 million invested in the program (which represented about 10 percent of ARC spending during the 1983-85 period). Substantial progress was registered with primary care being extended to an additional 194,000 people living in 40 counties not previously served, and 14 new primary care facilities were constructed and 11 others renovated. In addition, the physician recruitment program placed 350 physicians in underserved areas. Furthermore, prenatal care was extended to 9,000 maternal cases in 22 of the counties with high infant mortality rates. After the end of the finish-up program, the Commission essentially devolved health care issues to other state and federal agencies, with only modest direct investment by the Commission.

During the 1965 to 1990 period, Appalachia made considerable gains in health status with a significant improvement in infant mortality rates that paralleled the national gains and virtually closed the gap between the Region and nation, and a steady growth in the number of non-federal physicians per 10,000 persons. Furthermore, the increase in the number of health care facilities made quality health care more accessible. Yet, many health care indicators suggested that there were significant challenges related to affordable health care, shortages of health professionals, and persistent health-care problems in distressed communities that were indicative of health disparities.

The 1990s saw a revival in ARC's health investments, but these investments were made with eye toward leveraging resources from other public and private sources. The Commission recognized that given the limitations of its non-highway budget, the health

goal could not be achieved by the Commission alone. As a result, the Commission has focused on forging partnerships with the federal, state, and local governments and the private sector. Networks and coalitions have been formed by the Commission with a number of health-related agencies. In November 2000, the ARC formed a partnership with the National Health Services Corps and the Substance Abuse and Mental Health Services Administration to convene a regional conference on Mental Health and Substance Abuse. In partnership with the Centers for Disease Control, ARC has funded a diabetes initiative focused on education and treatment issues in the Region's most distressed counties.

In 2000, the Commission established the *Appalachian Health Policy Advisory Council* (AHPAC) which was charged with providing expert advice and analysis of critical public health information for the Commission, and identifying key opportunities for leveraging resources to address the Region's outstanding health needs. As a result, AHPAC recommended that ARC undertake research to assess the disparities in the health status, risks and accessibility to health care in the Region. Such research takes on elevated importance in light of the growing evidence of regional health disparities in the standardized mortality rates for certain types of cancers, such as cervical cancers among white Appalachian women, and lung cancers among white Appalachian men. Furthermore, the passage of the *Health Care Fairness Act of 2000,* which focuses on identifying significant health disparities for research, scientific planning, policy analysis and community-based research and outreach, has raised the policy prominence of such research, and the potential for leveraging further research dollars to examine the health issues of the Region.

In 2004 AHPAC accepted the report commissioned for the council by ARC on *An Analysis of Disparities in Health Status and Access to Medical Care in the Appalachian Region*. The report, which is described above, shows that significant health disparities persist in the Appalachian region. On September 19, 2005 the findings of this report were presented to the Agency on Health Research and Quality in an effort to secure more funding for further research, analysis and translation of these findings into community-based practice to address high disparity communities.

XI. Background on the Appalachian Regional Commission

The Appalachian Regional Commission is a federal-state partnership established in 1965 by the Appalachian Regional Development Act to promote economic and social development of the Appalachian Region. The Act, as amended in 2002, defines the Region as 410 counties comprising all of West Virginia and parts of Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia—an area of 200,000 square miles and about 22.9 million people. To promote local planning and implementation of ARC initiatives, the Commission established 72 Local Development Districts (LDDs) comprising groups of counties within each of the 13 states. The Commission has 14 members: the governors of the 13 Appalachian states and a federal co-chairman, who is appointed by the president.

For 41 years, the Commission has funded a wide range of programs in the Region, including highway corridors; community water and sewer facilities and other physical infrastructure; health, education, and human resource development; economic development programs and local capacity building, and leadership development. The rationale for ARC's Area Development program is to provide the basic building blocks that will enable Appalachian communities to create opportunities for self-sustaining economic development and improved quality of life. These strategic goals were agreed upon after an exhaustive, year-long strategic planning process involving federal, state, and local officials and citizens that focused investment in four goal areas:

1. Increase job opportunities and per capita income in Appalachia to reach parity with the nation.
2. Strengthen the capacity of the people of Appalachia to compete in the global economy.
3. Develop and improve Appalachia's infrastructure to make the Region economically competitive.
4. Build the Appalachian Development Highway System to reduce Appalachia's isolation.

Area Development funds are allocated to the states on a formula basis and each state has wide discretion in deploying those resources across the four goal areas based on local needs and state priorities. However, an overarching policy mandated by Congress is that ARC resources are to be targeted to those counties with the greatest needs—those still the farthest behind that are designated as "distressed."

In FY 2006, the Commission's definitions of economic development levels designated 77 counties as distressed because of high rates of poverty and unemployment and low rates of per capita market income compared to national averages; 303 counties were designated transitional (81 of these transitional counties may be characterized as "at-risk" of returning to distress), with higher than average rates of poverty and unemployment and lower per capita market income; 22 counties have nearly achieved parity with national socioeconomic norms and are now designated as competitive and; 8 counties have reached or exceeded national norms and are now designated as attainment counties. See ARC's web site for more details (http://www.arc.gov/).

XII. Selected Mental Health Disparities & Substance Abuse Publications

Edlund M.J., Belin T.R., Tang L. *Geographic variation in alcohol, drug, and mental health services utilization: what are the sources of the variation?* Journal of Mental Health Policy and Economics, in press.

Edlund M.J., Wang P.S., Berglund P., Katz S.J., Lin E., Kessler R.C. *Dropping out of mental health treatment: Patterns and predictors among epidemiological survey*

respondents in the United States and Ontario. American Journal of Psychiatry, 159(5), 845-851, 2002.

Fortney J.C., Booth B.M., Kirchner J.E., Han X. *Rural-urban differences in health care benefits of a community-based sample of at-risk drinkers*. Journal of Rural Health, 19(3), 292-298, 2003.

Fortney J.C., Booth B.M., Kirchner J.E., Williams D.K., Han X. *Differences between physical and behavioral health benefits in the health plans of at-risk drinkers*. Psychiatric Services, 54(1), 97-102, 2003.

Fortney J., Booth B.M. *Access to substance abuse services in rural areas.* In: Galanter M., editor. Recent Developments in Alcoholism, Services Research in an Era of Managed Care Volume XV, New York: Kluwer Academic/Plenum Publishers, 2001: 177-209.

Gerdner L.A., Beck C.K.. *Statewide survey to compare services provided for residents with dementia in special care units and non-special care units*. American Journal of Alzheimer's Disease and Other Dementias, 16(5), 289-295, 2001.

Harman J.S., Edlund M.J., Fortney JC. *Disparities in the adequacy of depression treatment in the United States.* Psychiatric Services, 55(12), 1379-1385, 2004.

Harris K.M., Edlund M.J., Larson S. *Racial and ethnic differences in the mental health problems and use of mental health care.* Medical Care, 43(8), 775-784, 2005.

Rockett, I.R.H., Putnam, S., Chang, C.F., and Smith. G.S., Unmet Substance Abuse Treatment Need, Health Services Utilization and Cost: A Population-Based Emergency Department Study. Annals of Emergency Medicine, 45(2), 118-127, 2005.

Rost K, Fortney J, Fischer E, Smith J. *Use, quality and outcomes of care for mental health: The rural perspective.* Medical Care Research and Review, 59(3):231-265, 2002.

Sullivan G., Han X., Moore S., Kotrla K. *Disparities in hospitalization of diabetics with and without co-occurring mental disorders.* Psychiatric Services, in press.

Walton M.A., Blow F.C., Booth B.M. *Diversity in relapse prevention needs: gender and race comparisons among substance abuse treatment patients.* American Journal of Drug and Alcohol Abuse, 27(2), 225-240, 2001.

XIII. Outline of Technical Proposal Contents

A. Technical Proposal.

Please note that the narrative of the proposal should not exceed 15 pages, (not including the abstract and accompanying long resumes and boilerplate organizational background materials which can be included as an appendix.)

1. ***Summary Abstract (350 words).*** In this section, provide a brief abstract of the technical portion of the proposal by summarizing the background, objectives, proposed methodology, and expected outputs and results of the research.

2. ***Methodology.*** State the step-by-step approach or methods intended to accomplish all the tasks specified in this RFP. The proposal should provide a detailed explanation of the methodologies to be used, describe the limits of the selected methods, and justify why the methods were selected over others. The proposal should identify the points and tasks in this research project that will require participation by the Commission and ARC staff. Further, the statement should identify specific information needs according to sources, procedures, and individual tasks of the research that may need to be supplied by the Commission. Finally, the proposal should identify any difficulties that may be encountered in this project and propose practical and sound solutions to these problems.

3. ***Project Work Plan and Milestones.*** The proposal should describe the phases into which the proposed research can be logically divided and performed together. Flow charts should be included as necessary. A schedule of milestones and deadlines should be specified for the completion of various work elements, including information collection, interviews, surveys, analyses, quarterly progress reports, preliminary drafts for review, and final draft reports.

4. ***Key Personnel.*** Personnel performing the research must be described in this section in terms of numbers of people and their professional classification (e.g., project director, economist, analyst, statistician, etc.). Brief resumes of the education and relevant experience of the principal investigator, co-investigator, and other key personnel are required. The selected contractor will be required to furnish the services of those identified in the proposal as key personnel. Any change in key personnel is subject to approval by ARC.

B. Management Proposal

The resource capability and program management for planning and performing the research will be considered in the proposal selection process.

1. ***Business Management Organization and Personnel.*** Furnish a brief narrative description of the organization, including the division or branch planned to perform the proposed effort, and the authority responsible for controlling these resources and personnel.

2. ***Staffing Plan.*** A staffing plan is required that describes the contractor's proposed staff distribution to accomplish this work. The staffing plan should present a chart that partitions the time commitment of each professional staff member to the project's tasks and schedule. In addition, the proposal should include a detailed description of activities for key project-related personnel and anticipated deliverables. Finally, the proposal should identify the relationship of key project personnel to the contracting organization, including consultants and subcontractors.

3. ***Relevant Prior Experience.*** The proposal must describe the qualifications and experience of the organization and the personnel to be assigned to the project. Information should include direct experience with the specific subject-matter area and organizations, addresses, contact persons, and telephone numbers for such references.

4. ***Contract Agreement Requirements.*** This section of the proposal should contain any special requirements that the contractor wants to have included in the contract.

C. Cost Proposal

Each proposal submitted must contain all cost information. The cost information should include direct labor costs (consistent with the staffing plan), labor overhead costs, transportation (if anticipated), estimated cost of any subcontracts, other direct costs (such as those for data bases and economic models), university overhead, total direct cost and overhead, and total cost and fee or profit.

In addition, ARC may choose to request that the selected contractor formally present and discuss study findings with key Appalachian officials in Washington, D.C. This activity will be over and above routine meetings with ARC staff during the course of the project, and the contractor should price its part in this activity separately, assuming travel to a one-day meeting.

The contract awarded for this research project will be a FIRM FIXED-PRICE CONTRACT, with payments on a quarterly schedule. The contract terms shall remain firm during the project and shall include all charges that may be incurred in fulfilling the terms of the contract.